

DOCUMENT RESUME

ED 199 582

CG 015 003

AUTHOR Webb, Carol
 TITLE The Rape Victim and Her Social Support System.
 PUB DATE Sep 80
 NOTE 23p.: Paper presented at the Annual Convention of the American Psychological Association (88th, Montreal, Quebec, Canada, September 1-5, 1980).

EDRS PRICE MF01/PC01 Plus Postage.
 DESCRIPTORS Attitude Change: *Coping: Counseling Services: Counselor Client Relationship: *Crisis Intervention: Emotional Response: *Family Influence: *Females: *Rape: Social Attitudes: State of the Art Reviews
 IDENTIFIERS *Support Systems

ABSTRACT

Few counseling services are available to or utilized by rape victims, which implies that many women turn, instead, to their social networks for support. Research literature suggests that anxiety is reduced and coping skills are enhanced when a victim uses her interpersonal social network for support. Unfortunately, many women have the same attitudes toward rape that are held by society, i.e., that rape is precipitated by the victim, and they are hesitant to tell persons in their social networks about their assault. Data from a rape crisis center revealed that most victims planned to tell at least one other person about the rape incident and that a significant relationship existed between plans to tell others and subsequent success in followup counseling. The results suggest that the family has a significant impact on rape victims: family members are most often turned to for support, yet are the most difficult individuals with whom to discuss the rape. For most women, the crisis intervention contact is the only contact she will experience with a trained counselor. It is important that the counselor, in addition to offering professional counseling, encourage the victim to use her social network for support. The new emphasis on the social support system of the victim can help the woman in her recovery process.
 (RNE)

 * Reproductions supplied by EDRS are the best that can be made *
 * from the original document. *

ED199582

THE RAPE VICTIM
and
HER SOCIAL SUPPORT SYSTEM

Paper Presented at APA, 1980
Montreal

Carol Webb
Emory University School of Medicine/
Grady Memorial Hospital
Atlanta, Georgia

U.S. DEPARTMENT OF HEALTH
EDUCATION & WELFARE
NATIONAL INSTITUTE OF
EDUCATION

THIS DOCUMENT HAS BEEN REPRODUCED EXACTLY AS RECEIVED FROM THE PERSON OR ORGANIZATION ORIGINATING IT. POINTS OF VIEW OR OPINIONS STATED DO NOT NECESSARILY REPRESENT OFFICIAL NATIONAL INSTITUTE OF EDUCATION POSITION OR POLICY.

"PERMISSION TO REPRODUCE THIS
MATERIAL HAS BEEN GRANTED BY

Carol Webb

TO THE EDUCATIONAL RESOURCES
INFORMATION CENTER (ERIC)

CG 015003

The crime of rape has been a part of every society for as long as history has been recorded. Only recently, however, has it been viewed as a crime against women, its offenders been subject to prosecution, or its victims been regarded as worthy of concern or sympathetic treatment. The intrapsychic processes of rape victims after a rape trauma have been studied and described by Burgess and Holmstrom (1974) and others (Hilberman, 1976; Notman and Nadelson, 1976; Sutherland and Scherl, 1970; Symonds, 1976). More and more evidence is being accumulated (Burgess and Holmstrom, 1979; Ellis, 1980; Kilpatrick, Veronen, & Resick, 1979) which indicates that psychological recovery from a rape trauma is a long term process which all too often is never completely resolved. With the increasing numbers of women reporting rape, and the lack of followup professional counseling services available or utilized by these women (King and Webb, in press), one can assume that many women turn to their social network to assist them in the recovery process. This paper addresses the issue of a rape victim's use or planned use of her social support system after a rape and relates the findings to clinical and counseling concerns for the victims.

A rape occurrence is a crisis situation, perceived by many women as life-threatening. The responses of women immediately after a rape are, for the most part, consistent with the responses of people in general to other crises. Coping mechanisms that are typically used to solve problems prove ineffective to handle the severe stress which follows a rape. A brief period of disorganization follows. This period is characterized by confusion, emotional reactions (fear, depression, anxiety, guilt), disruptions in functioning and somatic complaints. These reactions tend to gradually diminish in intensity over the few weeks and months immediately after the rape trauma until, at least theoretically, the victim is able to resolve the trauma and integrate this experience (albeit unpleasant) as one of her many life experiences.

Yet rape differs from other crises such as bereavement, illness, or robbery. Many women do not report the rape - estimates range from one in three reporting rape (Hursch, 1977), to one in ten women (FBI estimates), to one in fifty women (Medea and Thompson, 1974). Others may report the rape, receive medical treatment and then never tell anyone about it. Practically every woman will hesitate about telling people in her social network that she has been raped. She often feels a sense of shame and may blame herself, sometimes in quite creative ways, for having done something or having been somewhere she shouldn't have been which, in some way, precipitated the rape. This overwhelming feeling of shame and self blame is rarely seen in victims of other crimes. If you were mugged and robbed, would you hesitate to talk about it, elicit support from others and have them join with you in your anger at the assailant? During bereavement, women may feel guilty at having survived their husbands, but rarely would they feel shame; and rarely would they hesitate to tell their family, friends, or neighbors. One difference between rape and other crises lies in societal attitudes (Field, 1978; Calhoun, Selby, & Warring, 1976) which most women have incorporated concerning victim precipitation of rape.

The influence of the social network on assisting a rape victim in recovering from the trauma is enormous. Many authors (Burgess and Holmstrom, 1974; Fox and Scherl, 1975) agree that women who make extensive use of their support systems in their interpersonal social network cope better after a rape trauma than do women who keep the experience secret and private. Both the psychological and sociological literature, and clinical experience suggest that anxiety is reduced and coping skills are enhanced when a victim uses her interpersonal social network for support.

While there has been little experimental validation of the usefulness of the social network in reducing stress for rape victims, it has been demonstrated in other situations. Kissel (1965) demonstrated in the laboratory that the mere presence of a friend

(without any interaction) was sufficient to reduce stress as measured by GSR recordings in an unsolvable task situation. Quarantelli (1960), in a review of sociological studies of communities' response to natural disasters, found that between 65-75% of affected families received material and nonmaterial assistance from their social network. The hierarchy of help givers began with families and close friends first, friends and neighbors second, community organizations (churches, clubs) third, and public agencies last. Gurin, Veroff, and Feld (1960) found that younger people tended to rely more on their social network than older people. Others have found that families with limited social networks experienced less favorable outcomes after the husband's heart attack than did families with more extensive networks (Finlayson, 1976). In addition the kind of social network needed changed over time for bereaved women, from a close, homogenous one immediately after the death of the husband to a more extensive one during the reorganization phase (Walker, MacBride, & Vachan, 1977). People tend to use different parts of their social network for different needs - family is most relied on for financial and long term support, family and friends for moral or emotional support, and neighbors for short term services (taking care of the children for an hour) (Gourash, 1978; Litwak and Szeleny, 1969; Croog, Lipson, & Levine, 1972). These studies suggest that the use of the social network can significantly reduce stress and anxiety. The question remains as to whether rape victims turn to their social

network for support and, if so, what effect does that support have on the psychological outcome of rape.

Burgess and Holmstrom (1979) report that 78% of their sample of rape victims did tell at least one other person in their social network about the rape. Little other actual data on this issue could be found in the literature. In order to discover more about how rape victims planned to use their social support system after a rape trauma, data was collected from the Rape Crisis Center at Grady Memorial Hospital in Atlanta, Georgia. Grady is a large, urban hospital and the Rape Crisis Center serves the entire city. The following statistics were gathered from a random sample of the closed case file such that 10 cases from each month were represented. Thus the N of the sample equals 120, which is approximately 12% of the total number of cases seen annually. Only those cases in which a crisis center report was present and the victim was female were used. Statistics describing characteristics of the victim, the assault, the aftermath of the rape, and followup efforts are available in Appendix I. Certain differences based on age of the victim are also presented.

The Rape Crisis Center at Grady is primarily staffed by volunteer and student counselors. They are notified when a rape victim presents at the OB-GYN emergency room, and a counselor accompanies the victim throughout the hospital procedure, offering support, crisis intervention, and counseling. The average amount of time spent with a victim is 1½ hours during which the counselor

attempts to give the victim needed information about venereal disease and pregnancy, as well as to assess the victim's level of functioning and coping skills. Part of that assessment includes the following questions: who the victim plans to tell about the assault; who she doesn't want to tell; and who provides her with emotional support.

Data from this sample revealed that 85% of the victims planned to tell at least one other person about the assault, while 15% planned to tell no one. About 20% of the victims said both that they planned to tell some people about the assault and did not want others to know. Unfortunately data was available for only 51% of the sampled cases on the question of who they planned to tell and for only 20% of the sampled cases on the question of who they did not plan to tell. However, data was available for 80% of the sampled cases on the question of who they looked to for emotional support. Twenty-three percent of the victims indicated they would tell their spouse/lover/boyfriend; 52% indicated they would tell other members of their families (generally parents or siblings); 26% would tell their friends; 16% would tell a professional mental health worker; and only 6% would tell their coworkers. Because many of the victims indicated they would tell more than one person, these figures add up to more than 100%. The vast majority of rape victims depended on their families for social support. For those victims who identified persons they did not want to know, 13% indicated their spouse/lover/boyfriend; 48% their families;

10% their coworkers; and 19% their young children. Again, families are by far the most often identified by rape victims as being the group they do not want to know about the rape. Responses to the question about emotional support revealed that 7% of victims felt no one in their social system gave them emotional support; 14% reported their spouse/lover/boyfriend; 40% their family; 12% their friends; 12% professional mental health workers; and 6% others.

This data shows the significant impact of the family for rape victims. Families are the ones victims turn to for support, as well as the ones victims have the most difficulty in telling about the rape. Finally the data revealed no significant relationship between victims who choose to tell at least one other person in their social network and those who don't, with variables such as age, prior relationship with the assailant, or how they felt immediately after the rape. In other words, older victims were just as likely to tell or not tell others about the rape as young victims; it didn't matter whether the victim knew the assailant or not as to whether she would tell or not tell; and her emotional response immediately after the rape did not differ depending on whether she planned to tell or not tell others about the trauma. What was significant (both statistically and clinically) was the relationship between the victims plan to tell others about the trauma or not with success in followup counseling. It was more likely that victims who did plan to tell others receive at least one follow-up counseling contact from the rape crisis center than it was for victims who did not plan to tell others. This is especially

unfortunate for those victims who planned to keep the rape a secret, as they were denied, or denied themselves any outlet or social support after the rape trauma.

Basically these results are in agreement with much of the clinical literature on rape. There is a relatively small, but clinically significant number of women (15-20%) who, once having sought medical treatment, never tell anyone in their social network about the rape trauma. That these women are also deprived of follow-up counseling only adds to the difficulties that can be expected in their recovery process. Further, it is assumed that using one's social network for support would reduce the level of stress and enhance the level of functioning for victims of rape as it does for those in other crises. Research is presently being conducted to validate that assumption. An important variable is the response of the social network. Some important questions include: How does the rape victim perceive that response? Is it helpful? Does it reinforce societal attitudes about rape? It may be that psychological adjustment for a rape victim would be enhanced by telling no one over telling people who respond negatively or punitively to her.

The clinical and counseling issues which arise in this area are, I believe, significant ones. Followup counseling of rape victims is an area fraught with difficulties and, in general, most victims do not receive more than one followup contact (King and Webb, in press). Many crisis centers believe that if a woman has a social network that she uses for support, followup counseling

is not as important. For most women, the crisis intervention contact is the only contact with a trained counselor she will experience. It is very important that the counselor encourage her to use her social network, given that it is supportive, in addition to offering her the opportunity for professional counseling. More and more centers are looking at the effects of a rape on the family and they are using male counselors to talk with fathers, husbands, boyfriends, and brothers. The new emphasis on the social support system of the victim can only help the woman in her recovery process. Dispelling myths and ideas about victim precipitation of rape is an important part of the crisis intervention process with the victim. It is also an important to communicate this idea to those in her social network. Because most women receive emotional support from those people close to them, any assistance the counselor can offer to facilitate communication would be of great value to the long range mental health of the victim.

APPENDIX I

The Rape Crisis Center at Grady Memorial Hospital in Atlanta, Georgia saw over 1,000 rape victims in 1978. A statistical analysis of a random sample of those victims indicates various differences based on age of the victim. In addition to the obvious differences of occupation, education, marital status and with whom the victim lives, the findings support much of what has been written in the clinical literature. Specifically child rape victims (age 1 - 15) are more often assaulted by someone they know (acquaintance, friend, family member) and the rape occurs more often during the day than for older rape victims. In addition, a weapon (knife or gun) is less often used on a child victim than on an adult victim. Children report abuse other than the rape less often than do adult victims. (see Table V) As expected children are more often brought to the hospital, and the police notified by the family of the victim rather than, as with older victims, the victim herself notifying the police and coming to the hospital.

Surprisingly no statistical differences were found between children ages 1 - 15 and older victims ages 16 - 24 on variables such as where the rape occurred, whether the assailant knew where the victim lives or her name, or on what day the rape occurred.

These data appear to support the hypothesis that children are more often sexually assaulted by people known to them and that manipulative means rather than force are typically used. The immediate psychological consequences of such an assault are that children often have difficulty in trusting others, are blamed by parents for the assault, and may blame themselves. Children and adolescents show symptoms in less overt, direct ways than older victims. In spite of having symptoms such as fear of strangers or going outside, difficulties in school, problems with sleep or appetite, irritability, or somatic complaints (headaches, stomachaches) the children may not look sad, depressed or withdrawn. However, our experience suggests that children who are sexually abused do have psychological problems, are depressed, and need followup counseling.

In addition, the long term effects are assumed to be severe. This assumption is supported by the large numbers of adult psychiatric patients who report being sexually abused as children. Because the assailant is generally known and trusted by the child, long term difficulties in trusting others and forming significant interpersonal relationships may result.

Statistics from the
Rape Crisis Center
Grady Memorial Hospital
Atlanta, Georgia

The following statistics were gathered from a random sample of the 1978 closed case file such that 10 cases from each month were represented. Thus the N of the sample equals 120, which is approximately 12% of the total number of 1978 cases. Only those cases where a crisis center report was present and where the victim was female were used. Approximately 10% of the sample was rejected for not meeting the above qualifications and these cases were replaced.

Rape Crisis Center
Grady Memorial Hospital
Atlanta, Georgia

TABLE I
Characteristics of the Victim

Age:

average ($\bar{x}$) = 24.9

(σ) = 12.2

range 3-66

<u>years</u>	<u>% of sample</u>
1-15	14
16-24	51
25-40	26
41-66	9

Marital Status:

	<u>% of sample</u>
single	51
seperated/ divorced	26
married	11
widowed	3
missing	9

Ethnic Group:

	<u>% of sample</u>
white	32
black	64
missing	3

Education:

	<u>% of sample</u>
college	12
high school	9
grad	
some high school	20
9th grade or less	5
missing	55

Occupation:

	<u>% of sample</u>
unemployed	18
student	25
labor	15
professional	11
missing	30

Lives With:

	<u>% of sample</u>
spouse	12
roommate	10
parent	30
alone	11
other (children)	26
missing	11

TABLE I (cont.)
 Characteristics of the Victim

Lives In:

	<u>% of sample</u>
apartment	51
house	24
other	7
missing	17

Previous Rape:

	<u>% of sample</u>
yes	18
no	50
missing	31

Rape Crisis Center
Grady Memorial Hospital
Atlanta, Georgia

TABLE II
Characteristics of the Assault

<u>Day:</u>	<u>% of sample</u>	<u>Weapon:</u>	<u>% of sample</u>
Monday	13	none	12
Tuesday	9	knife	15
Wednesday	12	gun	19
Thursday	11	threat of	7
Friday	13	murder	
Saturday	24	threat of	27
Sunday	14	assault	
missing	4	missing	22

<u>Time:</u>	<u>% of sample</u>	<u>Sex Acts Performed:</u>	<u>% of sample</u>
7am-5pm	15	vaginal	68
5pm-midnight	25	vaginal and	8
midnight-7am	50	oral	
missing	11	other	9
		missing	14

<u>Where Assault Occurred:</u>	<u>% of sample</u>	<u>Other Abuse:</u>	<u>% of sample</u>
victims home	26	yes	31
street	10	no	12
neighborhood	17	missing	57
car	13		
unfamiliar	10		
place	10		
other	17		
missing	7		

TABLE II (cont.)
Characteristics of the Assault

Were Others Around:

	<u>% of sample</u>
yes	33
no	50
missing	17

Does Assailant Know Victims Name or Address:

	<u>% of sample</u>
yes	44
no	34
missing	22

Prior Relationship of Assailant and Victim:

	<u>% of sample</u>
stranger	51
acquaintance	18
friend	8
date	3
family	5
missing	14

Pape Crisis Center
Grady Memorial Hospital
Atlanta, Georgia

TABLE III
Aftermath of the Assault

How does Victim Feel about Assault:

	<u>% of sample</u>
1. not upset	1
2. somewhat upset	5
3. moderately upset	16
4. very upset	32
5. hysterical	9
missing	36

average ($\bar{x}$) = 3.7
(σ) = .9

How does Victim Feel about her Experiences at the Hospital:

	<u>% of sample</u>
1. not upset	45
2. somewhat upset	8
3. moderately upset	9
4. very upset	5
5. hysterical	2
missing	30

average ($\bar{x}$) = 1.8
(σ) = 1.2

Does Victim Fear Reprisal:

	<u>% of sample</u>
yes	22
no	47
missing	31

Were Police Notified:

	<u>% of sample</u>
yes	84
no	10
missing	6

How did Victim Get to Hospital:

	<u>% of sample</u>
police	57
family	20
friend	10
Victim	6
other	5
missing	2

Who Notified Police:

	<u>% of sample</u>
victim	40
family	18
other	18
missing	23

Rape Crisis Center
Grady Memorial Hospital
Atlanta, Georgia

TABLE IV
Counseling and Followup

Volunteer Time Spent with Victim:

minutes	<u>% of sample</u>
0 - 60	28
60 - 90	22
90 - 120	23
120 and up	26

average $(\bar{x}) = 105$ mode = 60
 $(\sigma) = 56$ median = 91

One Followup Contact Made:
(generally phone contact)

	<u>% of sample</u>
yes	42
no	56
missing	2

Followup Letter Sent:

	<u>% of sample</u>
yes	74
no	21
missing	4

More than One Followup Contact Made:

	<u>% of sample</u>
yes	13
no	83
missing	4

Other Followup Attempt Made:
(generally phone call)

	<u>% of sample</u>
yes	74
no	25
missing	1

Legal Followup Contact Made:

	<u>% of sample</u>
yes	23
no	72
missing	5

Rape Crisis Center
Grady Memorial Hospital
Atlanta, Georgia

Table V
Differences based on Age*

Age x Occupation	}	χ^2 (chi square) = .001
Age x Marital Status		
Age x Education		
Age x Lives With		

Age x Prior Relationship

χ^2 (chi square) = .01

<u>years</u>	<u>stranger</u>	<u>acquaintance</u>	<u>friend</u>	<u>family</u>
1-15	-	25	31	25
16-24	60	22	8	-
25-40	79	14	-	-
41 →	68	-	-	-

Age x Time of Day

χ^2 (chi square) = .07

<u>years</u>	<u>7am-5pm</u>	<u>5pm-midnight</u>	<u>midnight-7am</u>
1-15	42	42	-
16-24	9	23	68
25-40	17	30	53

Age x Weapon

χ^2 (chi square) = .03

<u>years</u>	<u>none</u>	<u>knife</u>	<u>gun</u>	<u>threat murder</u>	<u>threat assault</u>
1-15	36	29	-	-	29
16-24	14	12	37	10	26
25-40	-	31	15	-	38

*numbers reported are percentages

blanks (-) indicate percentages are not reported due to inadequate number of subjects in that category.

Rape Crisis Center
Grady Memorial Hospital
Atlanta, Georgia

Table V (cont.)
Differences based on Age

<u>Age</u> x <u>Abuse</u>			χ^2 (chi square) = .01
<u>years</u>	<u>yes</u>	<u>no</u>	
1-15	-	100	
16-24	73	27	
25-40	83	-	

<u>Age</u> x <u>Transportation to Hospital</u>				χ^2 (chi square) = .06
<u>years</u>	<u>by police</u>	<u>by family</u>	<u>by self</u>	
1-15	41	41	-	
16-24	64	14	7	
25-40	61	23	-	

<u>Age</u> x <u>Who called Police</u>				χ^2 (chi square) = .01
<u>years</u>	<u>victim</u>	<u>family</u>	<u>other</u>	
1-15	-	50	-	
16-24	53	23	17	
25-40	65	19	15	

REFERENCES

- Burgess, A. & Holmstrom, L. Rape trauma syndrome. American Journal of Psychiatry, 1974, 131, 981-986.
- Burgess, A. & Holmstrom, L. Rape: Sexual disruption and recovery. American Journal of Orthopsychiatry, 1979, 49, 648-657.
- Calhoun, L., Selby, J., & Warring, L. Social perception of the victim's causal role in rape: An exploratory examination of four factors. Human Relations, 1976, 29, 517-526
- Croog, S., Lipson, A., & Levine, S. Help patterns in severe illness: The roles of kin network, non-family resources, and institutions. Journal of Marriage and Family, 1972, 34, 32-41.
- Ellis, E., Calhoun, K. & Atkinson, B. Long term reactions to rape. Paper presented at APA, 1980, Montreal
- Field, H. Attitudes toward rape: A comparative analysis of police, rap crisis counselors, and citizens. Journal of Personality and Social Psychology, 1978, 36, 156-179.
- Finlayson, A. Social networks as coping resources. Social Science and Medicine, 1976, 10, 97-103.
- Fox, S. & Scherl, D. Crisis intervention with victims of rape. in L. Schultz, Rape Victimology. Springfield, Ill. Charles C. Thomas, Inc., 1975.
- Gourash, N. Help-seeking: A review of the literature. American Journal of Community Psychology, 1978, 6, 413-423.
- Gurin, G., Veroff, J., & Feld, S. Americans View their Mental Health. New York: Basic Books, Inc., 1960.
- Hilberman, E. The Rape Victim. New York: Basic Books, Inc., 1976.
- Hirsch, C. The Trouble with Rape. Chicago, Ill.: Nelson-Hall, 1977.
- Kilpatrick, D., Veronen, L., & Resick, P. The aftermath of rape: Recent empirical findings. American Journal of Orthopsychiatry, 1979, 49, 658-669.
- King, E. & Webb, C. Rape crisis centers: Progress and problems. in press, 1980

- Kissel, S. Stress-reducing properties of social stimuli. Journal of Personality and Social Psychology, 1965, 2, 378-384.
- Litwak, E. & Szelenyi, I. Primary group structures and their functions: Kin, neighbors, and friends. American Sociological Review, 1969, 34, 465-481.
- Medea, A. & Thompson, K. Against Rape. New York: Farrar, Straus, and Giroux, 1974.
- Notman, M. & Nadelson, C. Psychodynamic considerations: The rape victim. American Journal of Psychiatry, 1976, 133, 408-413.
- Quarantelli, E. A note on the protective function of the family in distress. Journal of Marriage and Family, 1960, 22, 263-264.
- Sutherland, S. & Scherl, D. Patterns of response among victims of rape. American Journal of Orthopsychiatry, 1970, 40, 503-510.
- Symonds, M. The rape victim: Psychological patterns of response. American Journal of Psychoanalysis, 1976, 36, 27-34.
- Walker, K., MacBride, A., & Vachon, M. Social support networks and the crisis of bereavement. Social Science and Medicine, 1977, 11, 35-41.